ADOT
Motor Vehicle Division
96-1510 R10/14 azdot.gov

Mail Drop 818Z
Medical Review Program
PO Box 2100
Phoenix AZ 85001-2100

ENDOCRINOLOGIST ANNUAL EVALUATION ARIZONA INTRASTATE DIABETES WAIVER PROGRAM CHECKLIST

Clear

Driver Identifying Information

Name:(first, mi, last)
Address: (city, state, zipcode)
DOB (mm/dd/yyyy)

This applicant was granted an Arizona Intrastate diabetes waiver from the Arizona Department of Transportation (ADOT) standard to operate a commercial motor vehicle (CMV) in intrastate commerce. ANNUAL medical monitoring and reporting is a condition of the waiver from the diabetes standard of Arizona Administrative Code (AAC) R17-5-208 and 49 CFR 391.41 (b) (3).

PLEASE CHECK / FILL IN REQUESTED INFORMATION.

1. ❑ I am board certified in endocrinology
   ❑ I am eligible in endocrinology

If neither, do not continue your assessment. Applicants must be evaluated by an endocrinologist who is board-certified or board-eligible.

2. Office Telephone number: _____Office Fax number: _____

3. Date of most recent examination: (mm/dd/yyyy)_____

4. I have reviewed the patient's daily glucose logs (from his/her glucose monitoring device).

❑ YES ❑ NO

5. I have compared monitoring dates to his/her driving log to ensure that the individual is checking glucose levels prior to operating a CMV as required.

❑ YES ❑ NO

If **NO**, please comment:_____

6. I certify that this individual's glucose levels have been maintained in the range of 100 to 400 mg/dl while driving a CMV.

❑ YES ❑ NO ❑ N/A

7. I certify that this individual continues to maintain a stable insulin regimen and that his/her glycosylated hemoglobin (AIC) result continues to reflect stable control of his/her insulin treated diabetes mellitus (ITDM).

❑ YES ❑ NO

8. FMCSA defines a **severe hypoglycemic reaction** as on that results in:
Seizure, or
Loss of consciousness, or
Requiring assistance of another person, or
Period of impaired cognitive function that occurred without warning.

In the last 12 months, while being treated for diabetes has the patient had a severe hypoglycemic episode? ❑ YES ❑ NO .

If yes, provide information on each hypoglycemic episode:
Date(s):_____

Include additional information about each episode including symptoms of hypoglycemic reaction, treatment, and suspected cause:

_____

_____

_____

Was the patient hospitalized . ❑ YES ❑ NO

If yes, provide brief summary of hospitalization:

_____

_____

_____

Has the patient's treatment regimen changed since the last hypoglycemic episode

❑ YES ❑ NO

Briefly explain changes:

_____

_____

_____

9. List all medications including those taken related to the treatment of diabetes (if none, write none)

Name of Medication	Dose	Reason for Taking The Medication

10. Has the patient continued to receive education in the management of diabetes that includes diet, monitoring, recognition and treatment of hypoglycemia and hyperglycemia?

❑ YES ❑ NO

If yes, please provide last education date: (mm/dd/yyyy)_____

Note: the applicant must participate in a diabetes education program at least annually to remain in the Arizona Intrastate diabetes waiver program.

11. I hereby certify that in my medical opinion, this applicant understands how to individually manage and monitor his/her diabetes mellitus. ❑ YES ❑ NO

12. Please describe the **progression** in diabetes complications/end organ diseases that have occurred in the **past year**: (if none, write none)

a. Renal disease:_____

_____

b. Cardiovascular disease:_____

_____

c. Neurological disease:_____

_____

Autonomic neuropathy ❑ YES ❑ NO (i.e. cardiovascular GI, GU)

Peripheral Neuropathy ❑ YES ❑ NO

If yes is check one below
❑ Sensory ❑ Decreased sensation ❑ Loss of vibratory sense ❑ Loss of position sense

13. Has the patient **developed** any of the following complications within the past year (please check yes or no):

Renal Disease	Renal insufficiency	❑ YES ❑ NO
	Proteinuria	❑ YES ❑ NO
	Nephrotic Syndrome	❑ YES ❑ NO
Cardiovascular Disease	Coronary artery disease	❑ YES ❑ NO
	Hypertension	❑ YES ❑ NO
	Transient ischemic attack	❑ YES ❑ NO
	Stroke	❑ YES ❑ NO
	Peripheral vascular disease	❑ YES ❑ NO
Neurological Disease	Autonomic neuropathy (i.e., cardiovascular GI, GU)	❑ YES ❑ NO
	Peripheral Neuropathy	❑ YES ❑ NO
	If yes is check one below	
	❑ Sensory	
	❑ Decreased sensation	
	❑ Loss of vibratory sense	
	❑ Loss of position sense	

Comments:_____

_____

_____

14. In your medical opinion, does any one of the listed medications have the potential to compromise the driver's ability to operate a CMV safely?

❑ YES ❑ NO

If yes, which medications(s)_____

_____

15. In my medical opinion, the applicant has demonstrated the ability and willingness to properly monitor and manage their diabetes.

❑ YES ❑ NO

16. I hereby certify that in my medical opinion, the applicant is able to safely operate a commercial motor vehicle (large truck or motor coach) in intrastate commerce while using insulin.

❑ YES ❑ NO

Printed name:	Signature:
License Number:	Today's date:
Date of Expiration:	State of Issue:

Please send this completed annual vision checklist to:

Mail Drop 818Z
Medical Review Program
PO Box 2100
Phoenix AZ 85001-2100

If you have any questions or need additional information, please call 602-771-2460.